Acuity Scale Instructions

Life Areas which have greater points assess activities that are potentially disabling to a client. Therefore these area have greater priority when developing an Individual Service Plan and assigning program support activities.

1. Interview the client following your agencies protocol and Assessment Standards.

2. Review all pertinent client documents, secondary assessments done by other professionals (if appropriate) and any relevant information available about the client's needs.

3. Check the appropriate indicators in each Life Area on the Acuity Scale.

4. Using your professional judgment, assign a Stage for each Life Area listed on the Acuity Scale. If there are compelling indicators, a higher stage may be assigned so that higher levels of support may be provided to stabilize the client.

5. The score is assigned based on the number at the top of each "Stage". It is not based on the numbers of indicators inside that Stage.

6. Total the points at the end of the Acuity Scale. Assign appropriate program support activities.

CASELOAD MANAGEMENT

New:

- Case is less than 1 month old
- Transfer from another agency
- Eligibility has been completed

Open

- Case 1 month or older, contact in last 6 months
- Established patient with ongoing contact
- Minimum needs with Individual Service Plan created

Closed to CM

- Administrative Discharge (threatens safety or the confidentiality of others, and or staff, falsifying information regarding diagnosis)
- Client deceased
- Client moved out of service area
- Client refuses CM services or requests closure
- Incarcerated in State or Federal Prison
- Lost to Follow up - (3 attempts in 6 months to contact client)
- No Case Management needs stated by client
- No contact in past 12 months or more
- Permanent transfer to another agency (after 90 days)
- Temporarily institutionalized (Hospitalized, Mental Health or Jail)

Acuity Scale Guidelines

Basic Stage 1: **0-9 points**

- Case Management Intake
- Annual Update/Reassessment
- Minimum contact (phone or face-to-face) every year to verify address/phone and check on client's status
- Documentation in progress notes.

Basic Stage 2: **9-18 points**

- Case Management Intake
- Annual Update/Reassessment
- Minimum contact every 90 days to verify address/phone and check on client's status
- None or Minimum Individual Service Plan needs reviewed every 90 days.
- Documentation in progress notes.

Moderate Stage 3: **19-36 points**

- Case Management Intake
- Annual Update/Reassessment
- Minimum contact every 65 days (phone or face-to-face)
- Evaluation of Individual Service Plan every 60 days
- Individual Service Plan goals, activities and outcomes are documented in either: progress notes or VA-CRS ISP form and VA-CRS Progress Notes.
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Intensive Stage 4: **37-54 points**

- Case Management Intake
- Annual Update/Reassessment
- Minimum contact every 30 days or less (by phone or face-to-face)
- Evaluation of Individual Service Plan every 30 days
- Multi-disciplinary team with Case Manager involvement
- Individual Service Plan goals, activities and outcomes are documented in either: progress notes or VA-CRS ISP form and VA-CRS Progress Notes.

COMPARISON OF LEVEL OF CM CONTACT

Level of Need	VDH Standards	New Acuity Scale	Old Acuity Scale
Basic	90 days	every year	every year
Basic 2	90 days	90 days	every year
Moderate	60 days	60 days	every 6 months
Intensive	30 days or less	30 days or less	every 3 months

NOTE : ALL ISPs must be reviewed <u>every 90 days</u> to comply with VDH standards.

Clients who are open to CM need an ISP written <u>within 30 calendar days</u>.

ACUITY SCALE Definitions and Strategies

Linked to Medical Care: Linking to medical care is defined as the patient actively engaged in HIV medical care as documented by client attending HIV medical care appointments.

1) **No Need:** Client is engaged with an HIV clinic, has a medical provider and states no problems with accessing HIV medical care.
   Strategies: Reassess in one year

2) **Basic Need:** This is a client who may occasionally miss medical appointments because of employment scheduling conflicts, transportation but misses less than 50% within a six month period.
   Strategies: Assess the client for barriers to access which include transportation issues and adherence to medical appointments; provide appropriate resources.

3) **Moderate Need:** This client is at risk for being lost to care due to frequently missed medical appointments OR is a new client that has just engaged with an HIV clinic for the first time.
   Strategies: Clients at risk for being lost to care will require more care coordination. Engage with the client to assess barriers to medical care. For new patients engaging in care at the initial appointment, continue to assess the client for any access barriers, follow-up after the first appointment and routinely check up on the client regarding future appointments.

4) **Intensive Need:** The client cannot be located after three attempts and hasn't been seen in the clinic for more than six months OR the client is newly diagnosed and needs to be linked to medical care through referral to HIV clinic.
   Strategies: If lost to care, refer to case findings and change client to inactive. Newly diagnosed clients should be immediately referred to an HIV clinic for initial intake.

Prescriptions for HIV Medications: HIV medication prescriptions is defined as having access to any prescribed HIV medication from a physician.

1) **No Need:** The client has prescription coverage through insurance (private, Medicare, Medicaid) and no problems with accessing medications OR client does not take any medications at this time.

2) **Basic Need:** The client has no prescription coverage and relies on ADAP for HIV medications.
   Strategies: Client will need to complete financial screening for ADAP every 12 months.

3) **Moderate Need:** The client either doesn't meet the criteria to qualify for ADAP OR has let their ADAP eligibility lapse and needs immediate access to medications.

Strategies: A referral can be made to the Patient Medication Fund ($500 per year) through CVHCC. CM can contact other patient assistance programs through pharmaceutical companies to help client afford medication.

4) **Intensive Need:** The client has not been financially screened for ADAP, has lost prescription coverage recently, OR is newly diagnosed and never linked with medication assistance programs.
Strategies: If eligible for ADAP, the client should be directed to financial screening at the VCUHS (828-0966) with a completed ADAP form in hand along with proof of income. Referrals can be initiated for PMF or PAP if emergency arises and client cannot access ADAP in a timely manner or is ineligible.

Prescriptions non-HIV: Access to any prescribed medication not related to HIV condition.

1) **No Need:** The client has prescription coverage through insurance (private, Medicare, Medicaid) and no problems with accessing medications or client does not take any medications at this time.

2) **Basic Need:** The client relies on VCC coverage (the financial screening for VCUHS clients w/o insurance and prescription coverage who meet a financial criteria) or other community programs for non-HIV medications
Strategies: Client will need to be financially screened for VCC coverage at the VCUHS every 12-months. PAP's may need to be contacted to assist the client in continuing accessing their medication.

3) **Intensive Need:** The client cannot afford the prescription co-pays for their non-HIV medications and will require referrals to PAP or PMF. This client is typically over-income or otherwise ineligible for VCC coverage.
Strategies: A referral can be made to the PMF through CVHCC only if the non-HIV medications are somehow related to HIV infection. CM can contact other patient assistance programs through pharmaceutical companies to help client afford medications.

4) **Intensive Need:** The client has not been financially screened for VCC, has lost prescription coverage recently, maxed out benefits OR has never linked with medication assistance program
Strategies: If eligible for VCC, the client should be directed to financial screening at the VCUHS (828-0966) and bring along proof of income. Referrals can be initiated for PMF (if medication is explicitly related to HIV infection) or PAP if emergency arises and client cannot access ADAP in timely manner or is ineligible.

Dental: Oral health care needs

1) **No need:** Client has no reported problems accessing routine dental care every six months.

2) **Basic Need:** The client misses one dental appointment in a 12 month period, but is able to get about 80% of dental work completed (includes preventative care, fillings and other restorative dental care)
Strategies: Help client identify barriers to missed appointments, target CM intervention towards helping clients stay engaged in dental care every six months to promote prevention of future dental issues.

3) **Moderate Need:** Client has no access to dental care or has not been seen by a dentist in more than one year.
Strategies: Complete a dental referral if client is RW eligible. If ineligible for RW, refer client to MCV School of Dentistry for dental care or other dental care in the community.

4) **Intensive Need:** Client has an emergency dental need that requires immediate attention such as an abscess tooth, infection, etc.
Strategies: Dental referral if client is RW eligible and give client emergency walk-in hours for Vernon J. Harris Dental Clinic (M, W, Th at 8 or 12:30, Friday at 8 only). Refer client to VCUHS School of Dentistry for emergency.

Nutritional Supplements – Supplements recommended/ordered by a physician for a medical need. This is not related to basic food needs!!!!!

1) **No Need:** Client has no special nutritional needs that require nutritional supplements.

2) **Basic Need:** The client has some unintentional weight loss (5% of baseline weight in 1 month or 10% in six months), financial difficulty in obtaining food, poor appetite/depression, or low to normal BMI along with active infection, nausea/vomiting/diarrhea.
Strategies: Refer client to nutritionist for assessment. CM may need to coordinate community resources such as food pantries to help client avoid becoming malnourished. CM should assess for other illnesses or depression that may be impacting client's ability to remain nourished.

3) **Moderate Need**: A client in acute need (surgery, discharge, underweight) and has a BMI less than 18.5 is in this category. Active infection is present (eg – oral/esophageal thrush, sores in mouth) or client has been recently discharged from hospital and is in need of nutritional supplements for medical reasons.
Strategies: Referral can be generated for Consumer Nutrition Program so the client can have access to a $25/mo gift card for medically necessary foods. Refer client to Fan Free Clinic to access food pantry where nutritional supplements such as Ensure and Boost can be obtained.

4) **Intensive Need:** A client's wasting is the involuntary weight loss of 10% of baseline body weight plus chronic diarrhea (two loose stools per day for thirty days) or chronic weakness and fever (more than 30 days) in the absence of concurrent illness or condition other than HIV infection that would explain the findings. Client will need access to nutritional supplements for three months or longer.
Strategies: In addition to intervention strategies outline in Stage 3, CM may need to help clients maintain access to such programs for longer than three months.

Activities of Daily Living: ADLs are the person's ability to bath, toilet, feed themselves, get out of bed, etc.

1) **No Need:** The client is independent and does not need any assistance with ADLs.

2) **Basic Need:** The client needs assistance for a maximum of four hours a day. The person may be mobile, but unable to shower or has a medical need (changing bandages, wound care).
Strategies: Refer client to home health and/or skilled nursing based on the Dr's orders. Most hospitals may already arrange this. Verify with client. A client may be in need for meals on wheels or other community based support service. The Department of Aging is another good resource to find out about community programs that assist the elderly, sick and disabled.

3) **Moderate Need:** The client needs ADL assistance more than four hours a day. The person is dependent on a caregiver to assist with cleaning, preparing meals, hygiene, etc.
Strategies: Same as Basic Need. Depending on the person's financial resources, CM may have to seek alternative funding to assist with home care need.

4) **Intensive Need:** The client is completely dependent for all care and needs to be supervised for 12-24 hours per day.
Strategies: If the client does not have a personal caregiver, CM may have to refer client to skilled nursing home facility or other type of rehabilitative care. If the person does have a caregiver, CM may make a referral to provide respite care for the caregiver so they may run errands or take a break.

Cognitive/Developmental Disability: Clients with C/DD are individuals that are mentally retarded, have had a brain injury of some sort or disease that has affected the person's ability to mentally function.

1) **No Need:** Client has no impairment (self-reported or observed).

2) **Basic Need:** Client is mildly retarded or has a mild impairment. The client remains independent, but may need a little extra assistance especially navigating the health system and social services.
Strategies: CM assess client's strengths and utilize those to assist the client in navigating complex systems. Some extra time spent with the client may be needed to help the client process paperwork, appointments and information.

3) **Moderate Need**: The client may or may not have a legal guardian. Comprehension and mental functional are significantly impaired.
Strategies: If the client has no legal guardian, assess to see if they are in need of one. If the client is not already in a supportive environment, the CM may have to work with them to find a structured environment to assist with the client's needs.

4) **Severe Need:** The client may or may not have a guardian and is severely impaired. The client has limited comprehension and is unable to function independently.
Strategies: Same as Moderate Need. Also refer the client for structured environment such as a group home. If no legal guardian, begin to work the system to identify a legal guardian.

End of Life Care: End of Life Care includes Hospice, home health, respite care and other supports during the final stages of life.

1) **No Need:** Not applicable or not required.

2) **Basic Need:** The client is already engaged in a nursing home, hospital and/or hospice.
Strategies: Follow up the medical support, identify any other client needs such as respite or support for patient and care givers. Verify end of life documents are complete and with the proper officials (living wills, executive power of attorney – health care).

3) **Moderate Need:** The client is not engaged in nursing home, hospital or hospice care and has a life expectancy of one year to six months.
Strategies: Refer to appropriate end of life care organization, verify end of life documentations, and provide additional emotional support to client and families. CM may also make mental health referrals to assist client and family with the news.

4) **Intense Need:** The client is in crisis. He/she has less than 6 months to live. Death is imminent at any time.
Strategies: Same as 3. Referrals and support services need to be in place very quickly.

PHYSICAL ENVIRONMENT

Utilities: Includes electricity, phone, water, heat…this does not include cable service!

1) **No Need:** Client does not require any financial assistance for paying monthly utilities

2) **Basic Need:** Client is in jeopardy of having a utility disconnected (1 month behind, or has received disconnection notice).
Strategy: CM may refer client to CVHCC Emergency Fund for assistance. CM may also need to work with client in contacting other community services (such as churches) to assist with payment). CM may refer client to budgeting classes.

3) **Moderate Need:** The client has had one utility disconnected or is imminent (24-48 hours) of having a utility disconnected.
Strategies: Same as 2. Identify barriers to paying utility bills on time.

4) **Intensive Need:** The client has more than one utility disconnected. This person may also be imminent danger of losing housing as well.
Strategies: If EF or other community funds is not enough to get utilities back on, CM may refer client to a shelter, temporary housing type of facility especially if housing is in jeopardy.

Food: Ability to eat two balanced meals per day per person in family.

1) **No Need:** The client and any family members within the household are eating at least two meals a day and does not request any food assistance.

2) **Basic Need:** The client and family members within the household are eating at least two meals a day 75% of the time or more. They may need food assistance.
Strategies: CM to assess for barriers to food. May refer to food bank, Fan Free pantry, budgeting courses.

3) **Moderate Need:** The client and/or family members are at risk of malnourished.
Strategies: CM to refer client to food bank and/or community food pantries for emergency food. Assess for barriers to food.

4) Intense Need: Client is malnourished.
Strategies: Medical assistance and evaluation may be necessary. Refer to food bank/pantries for emergency food including nutritional supplements. Refer to dietician and budgeting courses to assist in buying nutritional food on a budget. CM may also assist client in identifying shelters providing meals.

Transportation: To and from medical appointments.

1) **No Need:** The client has own transportation.

2) **Basic Need:** Client utilizes public transportation
Strategies: Client may need bus tickets from time to time.

3) **Moderate Need:** Client unable to access public transportation because they do not live on a bus routes and/or in a rural area. The client has sporadic transportation through family and friends.
Strategies: Refer to CVHCC transportation for assistance.

4) **Intensive Need:** The client is unable to access public and CVHCC transportation for medical appointments.
Strategy: To identify barriers to utilizing available transportation resources. Attempt to identify new resources (friends, family, community organization providing transportation).

FAMILY

Dependents: Includes children and adults that are living with the client.

1) **No Need**: Client has no dependents living with them.

2) **Basic Need:** Client has 1-2 dependents living with them.
Strategies: Depending on the client's situation, CM may need to assist client with finding day care and/or emotional support.

3) **Moderate Need:** Client has 3 or more dependents living with them OR has a dependent with special needs.
Strategies: CM may refer client for day care/respite care. Assess client's needs to determine if additional support or social services is needed in the residence.

4) **Intense Need:** Client has dependent(s) living with them in physical harm.
Strategies: CM will assess the situation. CM will need to report to Child Protective Services or Adult Services to file a complaint and have dependents removed.

Language: Includes foreign language, reading ability, blindness or hearing impaired or anything that requires communication assistance.

1) **No Need:** Client has no problems – fluent in English, has above a 9th grade reading level and/or has access to own tools to provide brail or sign language.

2) **Basic Need**: Client is bilingual or reading comprehension about 9th grade level.
Strategies: CM may need to provide a translator (including sign interpreter) on a rare occasion, or provide written materials in brail. Some additional assistance understanding complex reading materials may be needed.

3) **Moderate Need:** Client speaks no English but has own translator OR reading level below 9th grade level.
Strategies: CM may need to provide translation less than 50% of the time or spend additional time working with client to understand written materials.

4) Intense need: Client speaks no or little English and has no translator. Client is hearing impaired and needs an interpreter. The client could also be illiterate.
Strategies: Provide client with translator and/or sign language interpreter (Organization for the Hearing Impaired or through VCU rehabilitation services). Educational material will need to be presented through illustrations. May refer client to community reading courses (if client wishes). CM will have to do most benefit paperwork for the client.

MENTAL HEALTH/SUBSTANCE ABUSE

Support System: Through brief motivational interviewing techniques, assess the clients support network of friends and family.

1) **No Need:** The client self-reports strong support from family, friends and peers. Client states no needs.

2) **Basic Need:** Client self-reports having a strong support system, however is requesting additional support (e.g. support groups, peer support).

   Strategies: CM to refer client to support group, PACOV or other support network.

3) **Moderate Need:** Client may be new to area or has few family members/friends in local area.
   Strategies: Refer client to support groups, peer advocates and possibly mental health for counseling to assist with adjustment.

4) **Intense Need:** Client has no support system in place, no family, friends or peers…Client is in imminent danger of being in crisis.
   Strategies: Refer to crisis stabilization unit for assessment, refer to PACOV, support groups and mental health.

Mental Illness: CM is not diagnose the client, but based on observation and conversation with client, may determine a mental health assessment is warranted.

1) **No Need:** Client self-reports no history of mental illness and does not exhibit any behavior that may need an assessment.

2) **Basic Need:** Client reports mental illness or history of mental illness, however receives treatment and/or is evaluated consistently and condition is stable.
   Strategies: Reassess client every three months. Assess for any additional needs.

3) **Moderate Need:** Client may have mental illness or self-reports a mental illness and is not receiving treatment or is non-compliant to medications/treatment. Client may need to be evaluated.
   Strategies: Refer for psych/mental health evaluation. If client refuses referral or treatment, let him/her about available resources. You cannot force a client to treatment unless the client is a harm to themselves or others.

4) **Intense Need**: Client is a danger to self and/or others.
   Strategies: Call 911 If client is not in office, CM may go to magistrates' office and take an emergency commitment order out on the client.

Substance Abuse: any history of or self-report of drug usage including prescription drugs.

1) **No Need:** Client self-reports no history or use of drugs.

2) **Basic Need:** Client reports a history of drug use, but is abstinent and may still be currently receiving treatment.
Strategies: Assess client's needs. If client requests a listing of additional community supports, CM can provide information on AA/NA or other drug programs.

3) **Moderate Need**: Client reports having used substances but are currently receiving treatment.
Strategies: Assess the clients for any additional support needs.

4) **Intense Needs:** Client reports active use or is suspected of active use.
Strategies: CM may refer client to Rubicon or RBHA for treatment options.

Domestic Violence: Any physical or mental abuse to a partner.

1) **No Need:** Client self-reports no domestic violence history.

2) **Basic Need:** Client reports a history of domestic violence but not currently.
Strategies: Assess the client's current situation (are they still living together, seeing each other, what support mechanisms does she currently have). CM may refer client to YWCA for support groups.

3) **Moderate Need:** Client reports there has been domestic violence in the past year or CM observes visible evidence.
Strategies: Provide client with referral to YWCA or other community support. If client requests, CM may also assist client with any legal matters such as how to obtain a restraining order.

4) **Intensive Need:** Client reports current domestic violence and feels life is in danger.
Strategies: Call local law enforcement and/or emergency shelter such as YWCA. Assist client in getting necessary medical treatment if necessary.